Agenda for Today

- Analysis: What we know about the OHP population who may transition to BHP
- Report, Preliminary Recommendations and Discussion
- Redeterminations update
- Public Comment

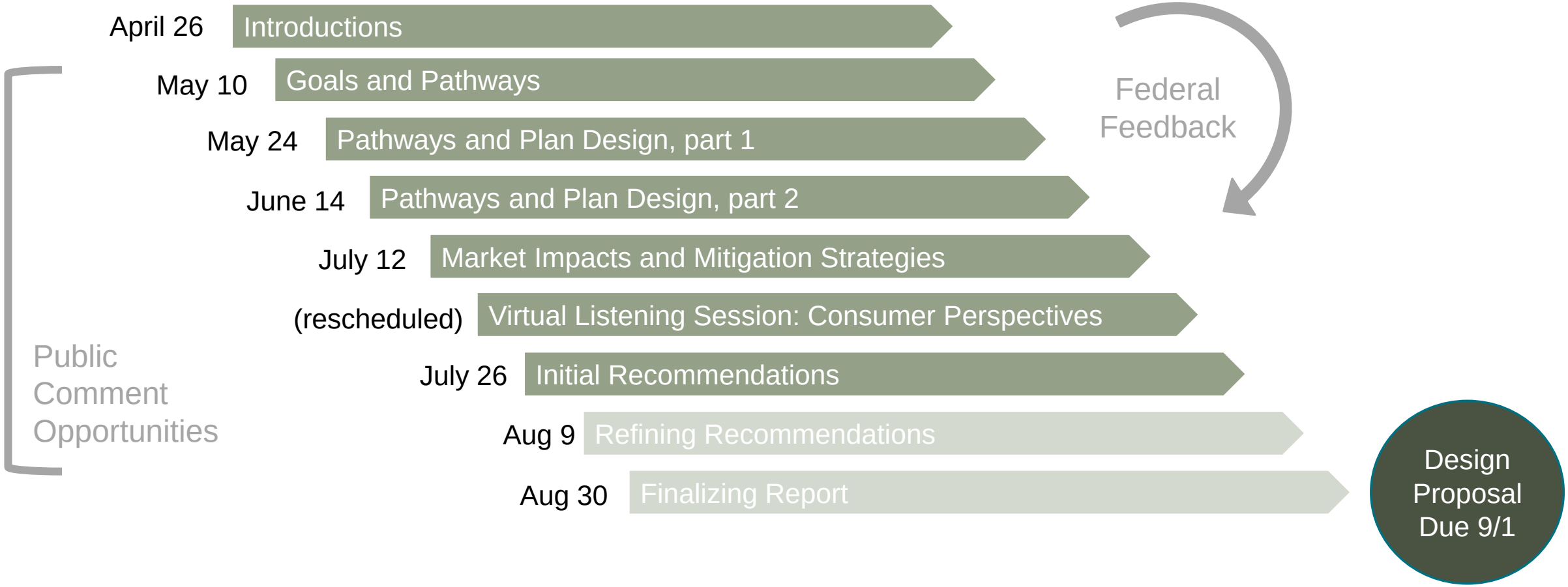
Report and Recommendations

NEXT STEPS

Goals for Today

- Review process
- Overview of first draft report and recommendations
- Q&A, discussion, revisions
- Confirm Task Force direction to staff for revising content

Where we've been



After Today

- Incorporate revisions
- Revised draft circulated to Task Force
- Presentation, revisions and vote on adoption 8/30
- Submission 9/1

Report and Recommendations

FIRST DRAFT

Recap: House Bill 4035

Requires the Task Force to submit plan design recommendations addressing

1. Federal pathway and timeline
2. Program and plan administration
3. Benefit design
4. If necessary, state budget request

Federal Pathway and Timeline: HB 4035

Requires consideration of:

1. 1115 waiver
2. 1331 blueprint
3. 1332 waiver

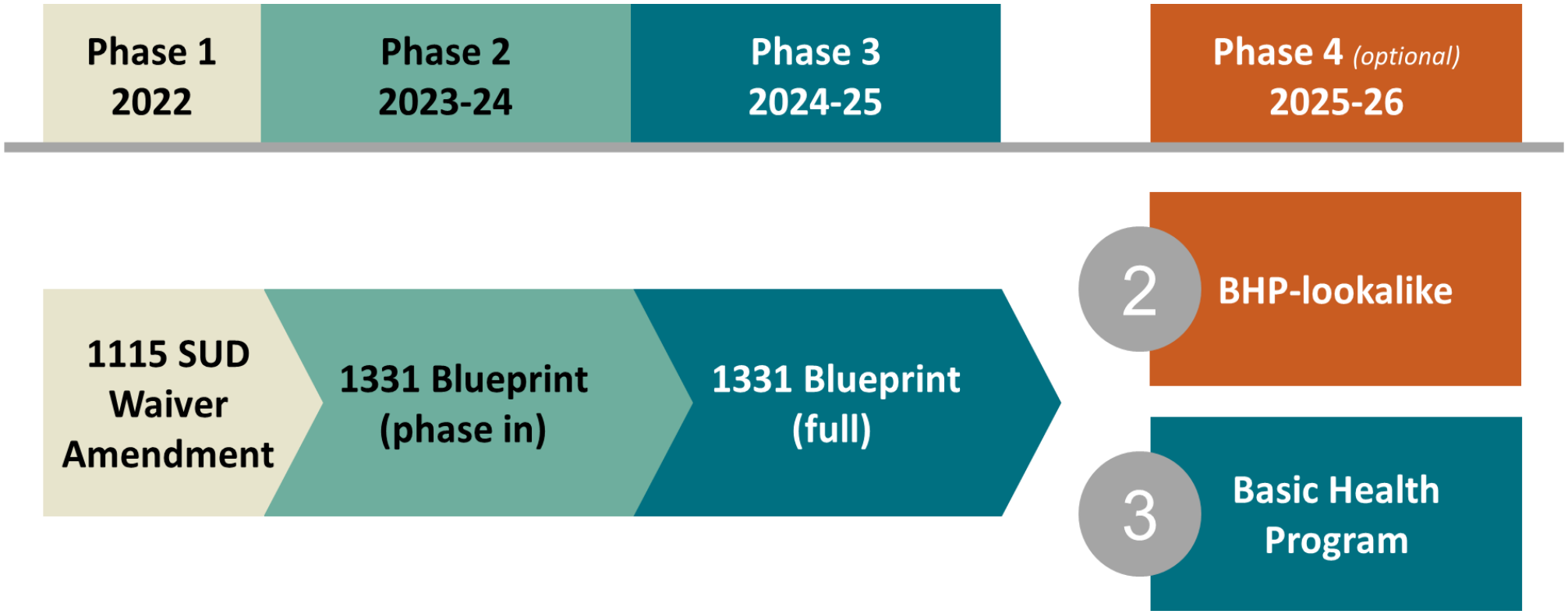
Must provide a transition period for enrollment

Must maximize Federal Financial Participation (FFP)

If possible, offer on Marketplace

Consider whether enrollees could opt out to the Marketplace

Federal Pathway and Timeline: CMS guidance



Federal Pathway and Timeline: Task Force Discussion

- 1115 not ideal for long term program funding.
- CMS guidance for 1331 is clear for near term.
- 1331 BHP can be offered on Healthcare.gov or a state exchange.
- Value in continuing to explore a 1332 waiver for “optionality” in the future (requires that Oregon is operating a state-based exchange).

Federal Pathway: Draft Recommendations

Oregon's Bridge Program should be established through a Section 1331 Basic Health Program Blueprint, as recommended by CMS.

The program should offer a transition period for enrollees by following the phased implementation approach suggested by CMS. The state should seek federal approval of the Blueprint on a timeline that will support Phase 3 implementation by 2025.

The program should be made available through Oregon's Marketplace, either by requesting modification of the federal Healthcare.gov platform or through a state-based marketplace, depending on the platform in use by phase 3.

OHA and DCBS should continue to explore with CMS the option to create a BHP-like product under Section 1332 waiver authority, which could enable Oregon to offer enrollees a choice between the Bridge Program and marketplace subsidies in phase 4.

Program and Plan Administration: House Bill 4035

- Ensure coverage for individuals up to 200% of the Federal Poverty Level who do not qualify for Oregon Health Plan.
- Offer coverage through CCOs with aligned procurement cycle.
- Enhance the coordinated care delivery system.
- Utilize capitation rates.
- If possible, rates higher than OHP.
- If possible, require CCOs to accept enrollees.

Program and Plan Administration: Feasibility Study

- Suggests Oregon could finance a program with **no enrollee cost sharing** and a covered service package **similar to CCO covered services** under 1331 Blueprint.
- Capitation rates could be somewhat higher than OHP; further analysis needed.
- Would reduce Oregon's percent of people without insurance coverage by 0.5 percent and may extend coverage to 21,300 Oregonians.

Program and Plan Administration: Additional Information

- OHP fee-for-service / open card will require different approach than standard BHP.
- New York pays rates approx. 25% higher than Medicaid. Minnesota requires parity between Medicaid and BHP rates.
- Federal law does not require BHPs to follow the prospective payment system for safety net providers; FQHCs may see lower reimbursements for BHP enrollees relative to OHP.

Program and Plan Administration: Task Force Input

- Medicaid provider networks are fragile and facing workforce shortages. OHP level rates may create barriers to access for BHP enrollees. “Keep providers whole” with rates above Medicaid levels.
- Differences in provider networks between OHP and Marketplace plans would affect continuity of providers for BHP enrollees.
- Consider how quality, cost-growth and VBP goals for BHP may differ from OHP.

Program and Plan Administration: Draft Recommendations

To promote continuous coverage for Oregonians, CCOs should be required to accept eligible enrollees to the program in the phased implementation manner outlined in this report. OHA should seek to develop enrollment procedures for each phase that emphasize continuity of care and provider access for enrollees transitioning to the Bridge Program from OHP and the Marketplace.

OHA should align procurement for the Bridge Program to existing OHP processes and timelines to minimize CCO administrative burden to launch the program. OHA should continue to engage CCOs through the Operations Collaborative to identify opportunities to operationally align the program to OHP.

If future actuarial analysis suggests the program can offer enrollees the full CCO covered service package at no enrollee costs and without reliance on state funding, OHA should establish capitation rates that enable CCOs to pay providers at levels higher than OHP.

Benefit Design: House Bill 4035

- Prioritize health equity and continuous coverage
- Provide, at a minimum, all essential health benefits
- If possible, provide dental coverage option(s)
- If possible, provide options that have no or limited enrollee out-of-pocket costs

Benefit Design: Additional Info Gathered

- Research suggests BHP population may be highly sensitive to monthly premiums.
- Research suggests out-of-pocket costs drive enrollees to avoid necessary care; communities of color disproportionately impacted.
- OHP service package includes all essential health benefits. Key differences between OHP and EHBs are dental, bariatric surgery and non-emergent medical transportation (NEMT). OHP pharmacy formulary broader than most Marketplace plans.
- Minnesota and New York incorporate cost sharing in BHP plans; program surpluses and ARPA have allowed this to be reduced over time.

Benefit Design: Task Force Input

- Different services between OHP and BHP could disrupt continuity of care
- Dental coverage a high priority (“the head is attached to the body”)
- Aligning to OHP covered services is lowest operational burden for CCOs
- Enrollee cost sharing highly undesirable as a plan design element
- CCOs will be challenged to implement cost sharing (premiums, copays)
- If cost sharing is necessary, state administration of a sliding scale premium is preferable to other approaches

Benefit Design: Draft Recommendations

Preliminary analysis suggests the Bridge Program could offer a covered service package that fully aligns to the CCO service package for OHP, including adult dental coverage. The CCO covered service package for OHP includes all essential health benefits.

The program could be offered to enrollees at no cost, including no monthly premiums and no out-of-pocket costs to access services. To minimize administrative complexity and enhance the CCO delivery system, Oregon's 1331 Blueprint should request waiver of the federal requirement to offer at least two BHP plans to eligible consumers.

State Budget: HB 4035

- Directs Task Force to minimize costs to the state
- Permits state budget request “if necessary”
- Otherwise “within [OHA’s] legislatively authorized budget” (LAB)

State Budget: Additional Info Gathered

1331 federal funding cannot be used for

- Program administration
- Covered services that are required under Oregon state law but cannot be paid for with federal funds

Feasibility analysis findings

Legislative intent

State Budget: Task Force Input

- If federal funding *cannot* support OHP benefits and capitation rates, Task Force would like to discuss state funding options along with enrollee costs
- If federal funds *can* support OHP covered services and no cost sharing, capitation rates should be higher than OHP

State Budget: Draft Recommendations

The feasibility analysis suggests the proposed Bridge Program design maximizes federal financial participation under a Section 1331 Blueprint. This federal pathway relies on a per capita funding formula that affords flexibility for enrollment to fluctuate over time without subjecting the state to federal budget neutrality requirements.

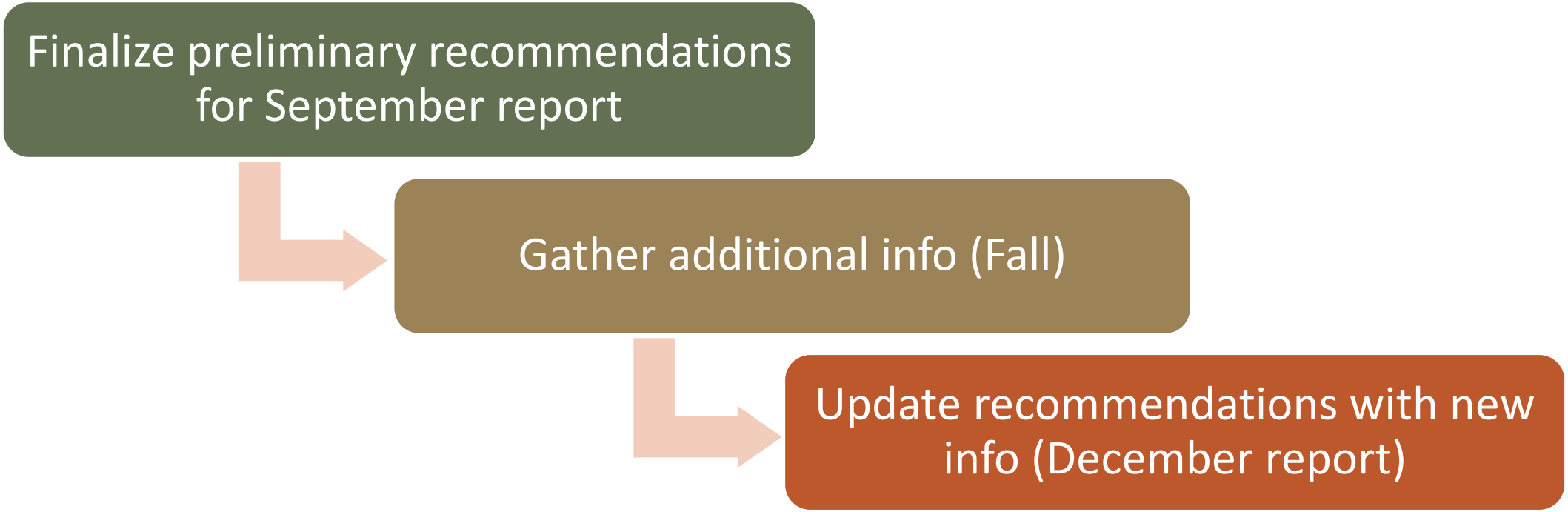
This approach does not depend on the extension of federal tax credit enhancements in the American Rescue Plan Act (2021) to minimize costs to the state budget.

These assumptions require further actuarial analysis that is anticipated in late 2022.

Information Still Needed

1. **The Section 1331 Basic Health Program federal funding formula for 2023 and beyond.** CMS had published a proposed rule for public comment. This proposed rule included several updates to the BHP funding formula that had the potential to shift the revenues Oregon would be projected to receive for its BHP.
2. **Actuarial analysis of the cost to cover the subset of the BHP-eligible population enrolled in OHP** under the continuous eligibility provision of the PHE declaration. This analysis was underway and slated for presentation later in August.
3. **Ongoing federal policy negotiations related to the enhanced APTC authorized in the American Rescue Plan Act of 2021.** These APTC enhancements were set to expire at the end of 2022, but Congress was considering a three-year extension of the tax credits. Because the federal formula for BHP funding tied program revenue to the value of APTCs, the pending expiration and potential extension of the enhancements had implications for Oregon's potential BHP revenue.

Next steps


Finalize preliminary recommendations for September report
Gather additional info (Fall)
Update recommendations with new info (December report)

Discussion

Staff will finalize report based feedback provided during today's meeting and sent to staff by Friday

Changes to report **recommendations** need to be made **TODAY**